## Welcome to the PAN-COVID register

Please circle your answers



CONSENT Has the participant provided verbal informed consent? Date provided consent DOB What is the participant's date of birth? NHS/ID no. What is the participant's hospital number (e.g. NHS or CHI)? EDD Does the participant have an expected date of delivery based on ultrasound? Yes No If yes, please provide the expected delivery date based on ultrasound If no, please provide the date of participant's last menstrual period вмі What is the participant's BMI? Date measured/calculated: Does the participant currently smoke cigarettes or tobacco? Yes, participant smokes **SMOKE** No, participant has never smoked No, participant used to smoke but stopped before this pregnancy No, participant stopped after they knew they were pregnant ETHNICITY European / North American What is the participant's ethnicity? Middle East Northern Africa Africa south of Sahara / Caribbean Indian subcontinent SE Asia South - Middle America Other COVID/ Please describe the status of participant's COVID-19 diagnosis? Date of test or first symptom onset SARS-CoV-2 Suspected infection Confirmed Negative test If suspected, please circle all symptoms which apply Fever New, persistent cough Anosmia Myalgia Diarrhoea Shortness of breath Fatigue Loss of appetite None of the above Medications Aspirin Yes Progesterone Yes No Immunosuppresion Yes No Low molecular weight heparin Yes No Any pregnancy vitamins Yes No Other Yes No None Yes No **Medical History** Chronic hypertension Yes No Pregnancy-induced hypertension Yes No Respiratory disease Cardiovascular disease Yes No Renal disease No Yes Autoimmune disease No Yes Pre-existing diabetes Yes No Gestational diabetes Yes No Other Yes Please list outcome of previous pregnancies (miscarriage/pregnancy Gravidity loss/livebirth, gestation, birthweight, neonatal death) **Pregnancy details** Please provide the number of fetuses the participant is carrying? Does the participant have pre-eclampsia? Yes No Does the participant have eclampsia? No Yes Does the participant have fetal growth restriction? If has fetal growth restriction, please circle all that apply Abdominal circumference or estimated fetal weight < 3rd centile Umbilical artery or uterine artery PI > 95th centile Abdominal circumference or estimated fetal weight reduced from 20/40 scan and crossed 40 centiles Cerebro-umbilical ratio < 5th centile Fetal structural malformation(s) present on ultrasound? Yes If yes, please circle all that apply Head Brain Central Nervous System Heart Limb Gastroenteritis Urinary Genital

Date of the participant's delivery? Was the participant's labour induced? What was the indication for delivery? What was the outcome of delivery?

Miscarriage Termination of pregnancy

Intra-uterine death/stillbirth (>22+6 weeks gestation)

If yes to miscarriage, did the woman have a previous ultrasound scan? If yes, please circle the diagnosis at the previous scan

Birthweight baby 1 (g) Birthweight baby 2 (g) Did COVID-19 lead to the participant requiring any of the following? Please circle all that apply and give dates

Viable intra-uterine pregnancy Pregnancy unknown viability Pregnancy unknown location

	Date started	Date stopped	
Non invasive ventilation			
Intubation and ventilation			
Did the participant die?	Yes	No	If yes, date
If Yes, please circle the presumed cause of death		COVID-19	
		Pregnancy related	
		Other	
If the participant had a livebirth, please provide the NHS number (or ID			
number) for the baby/babies delivered	Baby 1		
	Baby 2		
Please provide the gender of the baby/babies	Baby 1	Male	Female
	Baby 2	Male	Female
Congenital malformation(s) present at delivery?	Yes	No	
If yes, please circle all that apply	Head		
(if >1 baby, please indicate which baby affected)	Brain		
	Central Nervous System		
	Heart		
	Limb		
	Gastroenteritis		
	Urinary		
	Genital		
What was the APGAR score at 5 minutes?	Cemea		
Triat was the 7th of this score at 5 minutes.			
If >1 baby, what was the APGAR score of the second neonate at 5 minutes?			
Baby(s) separated from the participant immediately after delivery?	Yes	No	
If yes, how many days were they separated?			
Has the baby(s) received breastmilk from the participant?			
Has the baby(s) been tested for SARS-COV-2?	Yes	No	
If Yes, please indicate sample(s), date(s) and result(s)	Date	Sample	Result
		•	
Did the participant's neonate(s) experience any complications?	Yes	No	
If yes, please circle any that apply	Transient tachypnea of newborn		
If >1 baby, please indicate which baby/babies affected	Respiratory distress syndro	ome	
	Pneumonia		
	None of the above		
Did the participant's baby/babies die?	Yes	No	
If yes, what was the date of death	Baby 1		
	Baby 2		
If yes, what was the suspected cause of death	Baby 1		
If yes, what was the suspected cause of death	Baby 1 Baby 2		
If yes, what was the suspected cause of death  Was the participant's baby/babies re-admitted to hospital at any point			
Was the participant's baby/babies re-admitted to hospital at any point		No	
	Baby 2	No	